PERMANENCY PLANNING
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TABLE OF CONTENTS

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Section 315.100 Assessment

= = **a) Initial Assessment**

b) Comprehensive Assessment

c) Ongoing Assessment

Self-Administration

Before being allowed to self-administer medication, a child should be able to recognize and distinguish his/her medication, know how much to take and when to take it, know the reason for taking it, and understand the potential adverse reactions, side effects and/or other concerns for that medication. When medication administration requires more than the ability to swallow a pill, the child may be required to demonstrate the ability to self-administer that medication.

Authorization to allow a child to self-administer prescription medication requires the consensus of the foster parent/relative caregiver, the caseworker and the prescribing physician. The prescribing physician should provide a written order to this effect. The caseworker shall obtain a copy of the order.

The caseworker shall place the written order in the case record and shall note in the child's section of the service plan that the child may self-administer that specific medication.

Emergency/Rescue Medication

Some children will have medical conditions that require an immediate dose of emergency/rescue medication. The caseworker shall confirm that the foster parent has a current supply of this medication, instructions on when and how to administer the medication and the need to carry the medication at all times.

The caseworker shall obtain a written order from the prescribing physician authorizing the child to carry and self-administer emergency/rescue medication. This information shall be filed in the child's section of the case record and noted in the child's section of the service plan.

Runaways

When a child has a history of running away or the caseworker is notified that the child has threatened to runaway, the caseworker shall contact the caregiver and the child's doctor to discuss whether the caregiver should give any amount of a prescription medication to the child, or whether the caregiver should tell the child that he/she can get his/her medication by coming back to the foster home, contacting the caseworker or doctor, or going to an emergency room. The doctor's approval must be noted in a written

order, and must list the medications that the caregiver may give to the child. When a child has been authorized to carry emergency/rescue medication, the caseworker shall ensure that the doctor's order addresses these medications.

The caseworker shall obtain and review the written order, and place the order in the case record and make a note in the child's section of the service plan.

The caseworker shall ensure that the **CFS 680, Child Identification Form**, contains an accurate and complete list of the child's medications, and that this information is provided to law enforcement and the Child Location and Support Unit for Children (CLSU).

Child Refuses to Take Medication

When the caseworker is notified by a caregiver that a child is refusing to take his/her medications as directed by a physician (this can be prescribed or over-the-counter medication), the caseworker shall talk to the child about his/her reasons for refusing to take the medications and whether he/she understands the reason for taking it. If the child still refuses, the caseworker shall contact the prescribing physician for direction.

A child's refusal to take some medications may be life-threatening or pose long-term consequences to the child's health. The caseworker shall call the prescribing physician immediately in those instances.

Section 315.110 Worker Contacts and Interventions

The following procedures describe the minimum requirements for frequency of worker in-person contact with families, children, and foster care/relative caregivers. Also included are some minimum activities that must be included during the contacts. The activities described here do not comprise an exhaustive list of worker responsibilities and duties and does not excuse casework staff from performing those tasks not specifically mentioned here but which are outlined in other rules, procedures, and policy guides.

In all contacts with families, children, and foster care/relative caregivers, the requirements of Procedures 302.30 on the use of interpreters for non/limited English speaking clients and hearing impaired clients must be followed. See Procedures 302, Services Delivered by the Department, Section 302.30, Introduction.

a) Initial Intervention and Contact by Caseworker

1) The assigned caseworker or person assigned by the supervisor, if the assigned caseworker is unavailable, must attend the shelter care hearing in court. This initial meeting with the family should occur with the child protection service worker to ensure adequate communication between worker, investigation specialist and family.

2) The assigned caseworker must attempt face-to-face intervention and contact with the family in the home within five working days after the shelter care hearing or case assignment, whichever is earlier, unless the caseworker and supervisor believe, based upon the health, safety, and best interests of the child, that it is necessary to attempt contact sooner. If the family is unavailable, the caseworker shall make a second attempt within one working day after the failed attempt. If that attempt is also unsuccessful, the caseworker shall conduct a diligent search for the family.

b) Ongoing Intervention and Contact

1) With Families (from whom the child was removed)

If the permanency goal is reunification, the custodial families of children in placement shall be seen **in their homes** by the assigned caseworker at least monthly or more frequently as specified by the service plan.

If there are other children remaining at home, the caseworker is responsible for observing and monitoring the parenting skills exhibited with those children and the safety of those children. The caseworker shall also assist the parent/relative caregiver to assess and secure community resources which may be needed for the children (e.g., medical, education, social, mental health, alcohol and other drug abuse (AODA) treatment, etc.)

If the permanency goal is other than reunification and there are no other children in the home, monthly contact shall continue if parent-child visitation is still occurring.

If parental rights are terminated and there are no other children in the home, no further contacts are necessary.

2) With Children (in placement)

A) The assigned caseworker shall meet privately with any child in substitute care in the child's living arrangement within the first 72 hours of placement or replacement (excluding holidays and weekends) and at least once every two weeks for the first month immediately following initial placement or a change in placement and at least once every month thereafter, including adolescent youth and youth in independent living settings. The assigned caseworker will meet privately with children who have any identified special needs (children with mental and physical disabilities) at least twice a month according to the child's strengths and changing circumstances The only exception to the minimum monthly requirement is for children placed out-of-state. (See (g) below.) When visiting children in substitute care, the caseworker must interview verbal children out of the presence of the caregiver.

B) During the interview with children, the worker shall seek to determine the child's progress in care, as well as determining whether their safety and well being needs are being met. The worker shall attempt to confirm the information reported by the child through other sources such as the child's school or day care provider. The assigned worker will inquire about the frequency, duration and any issues related to parental and sibling visitation. For a parenting youth whose child is placed separately, the worker will inquire about the frequency, duration and quality of parent-child visitation.

C) At the same time, the caseworker shall observe and briefly interview (verbal children) all other foster children in the home who are not in their caseloads who are home at the time of the worker's visit. This requires that the caseworker know all the other children in the home, who serves them, and whether any of the other children have any special needs.

D) The worker shall ensure that all the workers of the other foster children in the home are aware of any caregiving issues the worker discovers during the visit. (See paragraph (d) below regarding the staffing that must be conducted when there are two or more foster children in one foster home with more than one worker.)

E) All visits are to be documented in a SACWIS Contact Note.

3) The above frequencies shall be followed, unless the supervisor, based on the assessment, determines and documents in the service plan that more frequent contact is required. Some examples of situations that may require more frequent contact include children or youth in crisis or experiencing traumatic events (school, medical, death of significant persons, placement disruption, frequent runaway, etc). The frequency of contact for each child in care will be evaluated during on-going supervision and during the quarterly file review. The determination of the need for increased, or decreased level of contact shall ensure that all service needs are met.

4) Contacts with Parents Who Become Pregnant (Open Intact Family/Placement Cases) and Pregnant Wards

When an intact or placement caseworker learns that i) a parent in an open intact family or placement case becomes pregnant, and that parent was previously indicated for abuse or neglect, or ii) a youth in the custody or guardianship of the Department becomes pregnant, the caseworker shall determine if there are any health or safety concerns for the new baby. If there are health or safety concerns and the pregnant parent or youth is refusing to provide the caseworker the baby's due date and the expected place of delivery, the caseworker shall take the following actions:

- two months prior to the anticipated due date, increase visits to the pregnant parent or youth's home to once a week;
- attempt to get the pregnant parent or youth to sign a consent allowing the caseworker to talk with her physician and with hospital personnel;
- document in a SACWIS note all attempts to secure from the pregnant parent or youth the anticipated due date, the expected place of delivery, and any related consents; and
- document in a SACWIS note all contacts with the parent or youth's family, extended family and any support network persons to seek information about the pregnancy and/or notification of the baby's birth.

c) Interventions and Contacts Following Reunification

During all interventions and contacts following reunification, during a portion of the contact, the caseworker must see and spend some time with the child outside the presence of the parent.

1) Initial Intervention and Contact

Following the return home of a child who has been in substitute care, an initial face-to-face intervention with the child and parent must be made via a visit in the home by the assigned caseworker within 24 to 72 hours after the child's return home. The timing of the visit will be based upon the safety plan completed when the child is returned home. If the family is unavailable, the caseworker shall make a second attempt within one working day after the failed attempt. If that attempt is also unsuccessful, the caseworker shall conduct a diligent search for the family.

2) First Month

Following the initial visit, weekly or more frequent intervention and contact, as determined by the supervisor, with the child and parent in the home is required for the first month following reunification. At least two of the visits during this first month after reunification must be unannounced.

3) Ongoing

Frequency of intervention and contact subsequent to the first month of reunification shall be at least monthly until such time as safety and risk assessments indicate that there are no longer sufficient safety or risk factors present to require continued contact**.** If a paramour was the indicated perpetrator, the frequency of contact must be weekly for the first three months, per paragraph (e) below**,** regardless of whether or not the paramour resides in the home.

d) Contact with Foster Families/Relative Caregivers

1) The assigned Department or purchase of service agency caseworker shall provide the primary foster parent caregiver caring for a child for whom the Department is responsible with an **in-home**, face-to-face visit within the first two weeks of placement and at least once per month thereafter or more often on an as needed basis in order to provide consultation and support. Face-to-face contacts with the primary foster parent may occur at the same time as contact with the children in placement is made, provided that children are given the opportunity to be seen and interviewed alone. If the caregiver is an unlicensed relative, the caseworker is responsible for in-home face-to-face consultation twice per month**.** (See NOTE under (d)(2)(B) below.) If there are two or more foster children in one foster home with more than one worker, their respective workers shall together meet at least once every six months with the foster parent, in the foster home, to discuss issues.

Caregivers who have children with special needs or emotional or behavioral problems shall have weekly contacts by the assigned caseworker, and twice monthly in-person visits by the assigned caseworker.

2) During in-home face-to-face contacts with caregivers, tasks the workers shall perform include but are not limited to:

A) All in-home contacts (licensed caregivers and unlicensed relative caregivers)

- Observe the caregiver's home for any health and safety issues (if evidence or circumstances indicate that a child's health and safety may be in jeopardy, a safety assessment must be done in accordance with the Child Endangerment Risk Assessment Protocol (CERAP). If workers observe licensing violations, they shall make a referral to the licensing unit (licensed caregiver only).

- Recognize, assess, and address any indication of unusual stress or problems within the home as it affects the caregiver's ability to care for the child, regardless of whether the worker or the caregiver raises the problem.

- Discuss the child's adjustment to the caregiver's home and any special needs of the child, as identified in the service plan. If other needs are identified, document and initiate a plan for meeting those needs.

- Discuss any family-child, sibling visitation that occurred since the last contact, if the caregiver supervised the visitation. If the visit was not supervised by the caregiver, discuss any visible changes the caregiver noticed in the child after the visit occurred.

  If parental visits are not occurring per the service plan, or sibling visits are not occurring the required minimum of two hours twice per month, develop a plan to ensure the visits begin within the next two weeks. If visits between a parenting youth and his/her child who is placed separately are not occurring per the service plan, the worker shall ensure that the visits begin within 2 business days.

- Discuss the child's current health status and identify any new behavioral or medical health needs and/or barriers to meeting the child's health care needs. Ask if the child has been prescribed any emergency/rescue medications and whether there have been any instances requiring the use of those medications.

  Review medication and behavior logs (CFS 534 and CFS 534-1) as applicable. Collect medication logs at each visit and place them in the child's record. (Medication logs are to be maintained for all over-the-counter, as well as prescription medications.) Ensure all required documentation is being maintained, for example

immunization records, missed appointments, well-child exams, vision, dental and hearing screenings. Verify that a Health Passport is maintained and updated for each child.

The caregiver shall be instructed to call the worker immediately (and document on the medication log) when:

- the child requires emergency medical assistance and 911 has been called or the child has been taken to the emergency room;
- a child refuses to take a prescribed medication;
- the child has an adverse drug reaction that does not require emergency medical assistance;
- there is a medication error or missed dose of medication;
- controlled substances, syringes or needles are missing.

- Discuss the child's educational needs and progress.

- Ensure that caregivers understand their responsibility in assisting the child/youth in the development of day-to-day skills within the home environment, as well as participating in the life skill assessment at age 14.

Periodically, as needed or required by Department Rules or Procedures:

- Review with the caregiver the child's portion of the service plan (at least every three months).

- Share with the caregiver any important new information about the child, subject to confidentiality provisions, that are necessary for the proper care of the child.

- Plan with caregivers for how to respond to crises, including whom to contact and how, and what the caseworkers and caregiver will do. Provide referrals as appropriate.

- Ensure that all required forms and paperwork are completed in a timely manner.

- Acknowledge and address attachment issues the foster parent may have with the child and its effect on the foster parent's support of the permanency goal.

- Inquire routinely if the foster parent needs additional training or support. If so, this information should be shared with the caregiver's licensing worker.

- Assess the need for support services to caregivers, such as employment related day care, reimbursement for travel or training expenses, respite care or placement stabilization services, and other services the Department is authorized to provide to foster and relative caregivers.

- Discuss the impact of the placement on the foster family's own children.

- Discuss with the caregiver the caregiver's responsibilities such as transporting children to counseling and/or medical appointments and allowing approved visitation or contact with siblings and biological parents. If the caregiver is not fulfilling these responsibilities or is in any way impeding the permanency plan for the child, the worker should discuss this with his or her supervisor.

B) Unlicensed relative caregivers

If the caregiver is an unlicensed relative, in addition to the tasks identified above, the worker shall over the course of the twice per month visits with the relative:

- Review with the relative caregiver all the conditions that prevent the relative from achieving full licensure.

- Discuss the relative's licensing status with the licensing representative. The worker and licensing representative are to actively assist the relative caregiver in achieving licensure.

- The worker shall document in the case record all the conditions that prevent licensure.

- The worker, licensing representative, and their respective supervisors must ensure that all identified safety and service concerns are fully addressed through specific plans and tasks.

NOTE: Caseworkers are to make twice monthly face-to-face visits with unlicensed relative caregivers, without exception, until the caregiver has been issued a foster care licensed by the Department. If it is determined that a relative caregiver cannot or will not be licensed, the caseworker shall continue to make face-to-face visits twice per month throughout the life of the placement.

e) Contacts with Paramour Involved Families

1) During the Investigation

Per **Procedures 300, Child Abuse and Neglect Investigations, Appendix H, Paramour Involved Families,** for all cases of physical abuse where a paramour has been named as an alleged perpetrator or identified as being involved with the family, investigative staff shall conduct **weekly** monitoring visits with the involved children during the course of all pending formal investigations, which have not yet been referred to follow-up staff, when the following conditions exist:

- a child victim is under ten years of age; or
- a child victim is vulnerable to physical abuse and injury due to a handicapping condition; or
- a child victim has been seriously injured.

The assigned Department or purchase of service agency caseworker shall conduct the weekly monitoring visit for families with open service cases unless other arrangements are made with the investigation specialist. Child welfare staff shall document monitoring visits in a SACWIS Contact Note.

2) Intact Family and Reunification Cases

Per **Procedures 302, Services Delivered by the Department, Subpart B, Section 302.250, Reports Involving Paramour Involved Families**, during the first three months of a new intact family or reunification case**, in which a paramour was identified as the indicated perpetrator,** child welfare workers must observe the child victims weekly for possible injuries and interview them, if verbal. Children are not to be interviewed with either the paramour or natural parent present. Department and purchase of service agency casework supervisors must approve any decrease in the number of monitoring visits and document his or her decision in the case file.

f) Children Placed in Residential Facilities

DCFS caseworkers are expected to maintain regular contacts with youth in residential facilities. The assigned DCFS caseworker* will visit the facility and meet, in person, at least monthly, with the residential provider and youth to review treatment progress and the planned discharge date.

*Only the assigned worker (or supervisor, if the worker is on leave) can make the visit. “Pooled visits”, whereby a worker will visit all the youth on his/her team, are not allowed.

g) Children in Out of State Placements

Children who are placed out of state in a foster home, relative home or in a residential facility, in compliance with 89 Ill. Adm. Code 328, Interstate Placement of Children, must be visited no less frequently than every six months by a caseworker of the Department or of the state in which the child has been placed**.** If the caseworker from the state in which the child is placed conducts the visits, that worker must provide the DCFS worker with a quarterly report addressing the child's adjustment to the placement, health and well-being, school, progress in treatment, etc. A DCFS or POS worker who visits a child placed in Illinois from another state shall provide the out of state worker with the same quarterly report. In either case, the supervising caseworker must submit the quarterly report to their respective interstate office, and not directly to the other caseworker.

h) Youth in Independent Living

Youth in independent living shall have weekly face-to-face contact with their caseworker during the first month the youth is living independently. At least two of the contacts should be in the youth's home (living arrangement).

After the first month, face-to-face contact with the youth shall be made at least twice per month. At least one of these contacts should be in the youth's home.

The casework interventions and tasks required during contacts with youth in independent living are described in the procedures governing the various independent living programs contained in the Appendixes to Procedures 302, Services Delivered by the Department.

i) Time and Location of Worker Contacts and Visits

Whenever it is necessary to have face-to-face visits with parents, children, or foster parents and relative caregivers, with the exception of required unannounced visits and those visits that must be made in the home, caseworkers shall make substantial efforts to be flexible and attempt as much as possible to schedule visits at a time and place where the persons they need to see can attend. Staff shall take into consideration parents work schedules, school age children's school attendance, transportation issues, availability of interpreters (if the parents' primary language of communication is other than English), and any other barriers that might prevent parents from participating. Parents should be reminded of the court admonishment to cooperate with the Department and that refusal or chronic failure to meet with the caseworker may be considered by the Department and the court as a lack of reasonable progress.

j) Telephone Contacts

The worker shall formulate a plan for communication between the worker and the child's parent(s), worker and the child/youth**,** and the worker and the caregiver. Workers should return all telephone calls within 24 hours**,** if possible**.** The worker shall provide the

members of the child family team with a contingency plan for emergency situations, for times when a worker is unable to return the call for any reason (vacation, illness, training, etc), such as making sure that they have the supervisor's phone number.

k) Contacts with Child's School

The worker shall meet with the child's teacher at least twice per year to discuss the child's progress or any other school related needs the child might have. Refer to **Procedures 314, Educational Services, Section 314.80, School Records, subsection (c) Documentation of Educational Services,** for more complete information on educational requirements.

When a child is returned home, the worker shall confer with the child's teacher or day care program provider at least monthly during the first quarter after return home and quarterly thereafter until case closure to discuss the child's progress and whether the teacher has any other observations regarding the child's health, safety, and well-being in the care of his or her parents. If the child is of pre-school age, the caseworker shall assist the parent in enrolling the child in a program such as early education or protective day care where indicated. The worker shall request that the teacher or day care provider notify the caseworker if the child is absent for two consecutive days.

APPENDIX A – CHILD ENDANGERMENT RISK ASSESSMENT

A. Requirements for Use of the Child Endangerment Risk Assessment Protocol

The **Child Endangerment Risk Assessment Protocol** (CERAP) is used within the larger protocols of CPI and CWS practice. It is a "life-of-the case" protocol designed to provide workers with a mechanism for quickly assessing the potential for moderate to severe harm immediately or in the near future and for taking quick action to protect children. Workers utilize the protocol to help focus their decision-making to determine whether a child is safe or unsafe and, if unsafe, deciding what measures or actions must be taken to assure the safety of the child. The major steps which are required to apply the protocol include an assessment and analysis of the safety factors, the completion of the **CFS 1441, Safety Determination Form**, and implementing and monitoring **the CFS 1441-A, Safety Plan,** when necessary.

Department staff and contracted private agency staff are required to utilize the Child Endangerment Risk Assessment Protocol (CERAP) and complete the **CFS 1441** at the specified time frames and at any other time when the worker suspects or believes that a child may be unsafe. The CERAP helps to assess the safety of each child with whom there is contact, either through child protection services or child welfare services.

B. Definitions

"Degree of Harm" means the severity of harm which could range from slight to moderate to severe.

"Expanded Safety Factors" means those conditions which are directly associated with immediate harm and are likely to predict when the child could be in immediate danger of moderate to severe harm if an intervention is not made.

"Immediate" means that an incident can happen now or in the very near future.

"Moderate to Severe Harm" means threat of danger to a child's life or health, impairment to his or her physical or mental well-being, or disfigurement.

"Near Future" means the time period immediately after contact with a child during which a child would be likely to suffer moderate to severe harm (i.e., be in danger) if NO protective action is taken to ensure the child's safety.

"Risk Determination" means the likelihood of any degree of long-term future harm or maltreatment.

"Safety Determination" (i.e., safe/safety) means a child is considered to be safe when an assessment of available information supports the belief that a child in a household or in custodial care is not in immediate (or near future) danger of moderate to severe harm.

C. Child Endangerment Risk Assessment Protocol

The Child Endangerment Risk Assessment Protocol (CERAP) is a process whose purpose is to identify the risk of moderate to severe harm (i.e. "safety" concerns) in the immediate future. When such immediate risk to the child's safety is identified, the protocol requires the implementation of a safety plan to control or immediately resolve or reduce the potential imminent risk of moderate to severe harm to a child. These safety concerns and the safety plan to control them must be documented on the **CFS 1441**, **Safety Determination Form** and the **CFS 1441-A, Safety Plan**. The Child Endangerment Risk Assessment Protocol (CERAP) is a process that is NOT unique to just one stage of a case, but is to be adhered to throughout the life of an open case from the initial intake (child protection or child welfare) through services to case closure. This protocol must be integrated with the Department's ongoing determination of "longer-term risk of harm" which is currently documented on the CFS 1440 series of forms and which serves as a basis for client service planning efforts to resolve long-term risk issues.

1. Safety and Risk

Safety is best understood when it is compared to risk. Safety and risk of children are determined by the consideration of behavior, condition, and accessibility of the child(ren) and the persons who have contact with the child(ren). Safety is a subset of the broader concept of risk, therefore all factors which apply to safety also apply to risk. However, not all risk factors apply to safety because safety is a form of risk that is more precisely defined or specialized.

Safety concerns are restricted to the essential criteria of "immediacy and degree of harm". Since risk allows a broader concept for evaluation of the family, safety concerns are depicted within the broader meaning of risk. The purpose of the broader area of risk is not control, but rather to decrease the risk of future maltreatment and resolve problems that cause risk. Safety factors are to be controlled and risk factors are to be resolved or reduced.

2. Similarities Between Safety and Risk

Safety and risk are similar in some very important ways, one being the prediction of harm. In the case of both safety and risk, there is a concern about the potential for future harm. Past harm and threats of future harm may describe both an immediate and long-term concern regarding a child's safety and are common to safety and risk.

Safety and risk both relate to the conditions of the home environment, or the behavior or the physical/mental condition of a family member or an interaction in the family. These conditions may predict immediate or short-term potential for harm (safety) or longer-term potential for harm (risk). Safety and risk elements can change quickly. Often they can be controlled or reduced by utilizing family strengths or other mitigating strengths and circumstances. In some cases, it may be necessary to address the problems with specific interventions designed to protect the child.

3. Differences Between Safety and Risk

The time element is the major difference between safety and risk. Safety means now or in the very near future and risk means longer-term. Safety and risk also differ by the degree of harm or the severity of the potential harm. Primarily, safety concerns itself with the potential for moderate to severe harm but risk is concerned with a full range of severity of harm, from low to severe.

The primary purpose of safety is to control the situation to prevent harm from occurring in the short-term, while the primary purpose of risk is to reduce or resolve the problems that lead to risk. Safety and risk both require intervention in order to prevent harm, but safety must always be assessed quickly, while risk may be assessed over a longer period of time.

D. Instructions for Completing the Safety Determination Form

Identifying Information:

Enter the case name, the date of the SCR report (if applicable), date of the current assessment, agency name, region/team/office or region/site/field, the name and ID of the investigator or worker completing this assessment, and the SCR/CYCIS number.

When to Complete the Form (Milestones - pages 1and 2):

The Child Endangerment Risk Assessment Protocol must be completed on the **CFS 1441, Safety Determination Form**, minimally at the following times:

For Child Protection Investigation and Child Welfare Intake Purposes

1) Within 24 hours after the investigator SEES the alleged child victims. At the initial safety assessment, all alleged child victims and all other children residing in the home are to be seen and if verbal, interviewed out of the presence of the caretaker and alleged perpetrator, if possible. If some children are not at home during the initial investigation, do not delay the safety assessment. Complete a new safety assessment on the children who are not home at the earliest opportunity, only if the safety assessment changes. If there is no change, certify the current assessment at the bottom of page 4 of the **CFS 1441** and enter the date of the certification on page 1. For all other safety assessments, all children residing in the home are to be seen, and if verbal, interviewed out of the presence of the caretaker and alleged perpetrator.

   If a worker initiates an investigation after hours and conducts the initial CERAP and hands the case off to a child protection investigator on the next work day, the CPI shall complete a new CERAP to verify the current safety of the child(ren).

2) Whenever evidence or circumstances suggest that a child's safety may be in jeopardy.

3) Every five working days following the determination that any child in a family is **unsafe** and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe **or** all unsafe children are removed from the **legal** custody of their parents/caretakers. This assessment should be conducted considering the child's safety status as if there was no safety plan (i.e., Would the child be safe WITHOUT the safety plan?).

4) At the conclusion of the formal investigation, unless a service case is opened. All children in the home, alleged victims and non-involved children, must be included. This provision may be waived by the supervisor if the initial safety assessment was marked safe and no more than 30 days have elapsed since it was completed.

5) At Child Welfare Services (CWS) Intake within 24 hours of seeing the child(ren).

For intact family purposes, the safety assessment must be conducted, at a minimum, at the following case milestones:

1) Within 5 working days after initial case assignment and within 5 working days upon any and all subsequent case transfers. **Note: If the child abuse/neglect investigation is pending at the time of case assignment, the Child Protection Service Worker remains responsible for safety assessment and safety planning until the investigation is complete.**

2) Every 6 months from case opening.

3) When considering whether to close an intact service case, a safety assessment must be done immediately prior to supervisory approval of the critical decision.

4) Every five working days following the determination that any child in a family is unsafe and a safety plan is implemented. Such assessment must continue until either all children are assessed as being safe or all unsafe children are removed from the legal custody of their parents/caretakers. This assessment should be conducted considering the child's safety status as if there was no safety plan (i.e., would the child be safe WITHOUT the safety plan?).

5) Whenever evidence or circumstances suggest that the child's safety may be in jeopardy.

For placement cases, the safety assessment must be conducted, at a minimum, at the following case milestones (check the appropriate box):

1) Within 5 working days after initial case assignment and upon any and all subsequent case transfers when there are other children still in the home as part of an open

family case assigned to the worker. Assess safety in the child's return home environment and document the conditions or behavior which continue to prevent return home and document the continuous safety of every child still in the home. **Note: If the child abuse/neglect investigation is pending at the time of case assignment, the Child Protection Service Worker remains responsible for safety assessment and safety planning until the investigation is complete.**

2) When considering the commencement of unsupervised visits in home of parent or guardian. (Assess safety in the child's return home environment.)

3) Before an administrative case review when a child in care has a return home goal and there are other children still in the home as part of an open family case **assigned to the worker**. Assess safety in the child's return home environment and document the conditions or behavior which continue to prevent return home and document the continuous safety of every child still in the home.

4) Every six months from family case opening when a child in care has a permanency goal other than return home and other children are still in the home as part of an open family case assigned to the worker. The safety assessment is to be completed on the children still at home only.

5) Within 24 hours prior to returning a child home. (Assess safety in the child's return home environment.)

6) Within five working days after a child is returned home and every month thereafter until the family case is closed.

7) Every five working days following the determination that any child reunified with his/her family is **unsafe** and a safety plan is implemented. Such assessment must continue until all children are assessed as being safe **or** all unsafe children are removed from the **legal** custody of their parents/caretakers. This assessment should be conducted considering the child's safety status as if there was no safety plan (i.e., Would the child be safe WITHOUT the safety plan?).

8) When considering whether to close a reunification service case, a safety assessment must be done immediately prior to supervisory approval of the critical decision.

9) Whenever evidence or circumstances suggest that the child's safety may be in jeopardy in home of foster parent, relative caregiver, or pre-adoptive parent. Enter the name of the caregiver in the space provided on page one of the **CFS 1441**.

Clarifications Regarding When CERAPs Are Conducted:

Foster/Relative care homes: CERAPS are **not** to be conducted on foster, relative care, or pre-adoptive homes unless evidence or circumstances suggest that a child's safety may be

in jeopardy. Such circumstances include all situations where the foster/relative/pre-adoptive home caretaker or any members of their household are identified as alleged perpetrators in a new report of child abuse/neglect of a child presently or previously living in the home.

Prior to administrative case review: A CERAP must be completed prior to an ACR when a child in care has a return home permanency goal and there are other children still in the home. A CERAP does NOT have to be completed prior to an ACR when:

- a child in care has a permanency goal of return home, there are no other children still in the home and there is no plan for the child to return home in the near future; or
- a child in care has a permanency goal of other than return home and there are no other children still in the home; or
- a child has a permanency goal of other than return home and there are other children still in the home. In this case a CERAP must be completed on the children still at home at least once every six months from date of family case opening until the family case is closed.

Case assignments/transfers: A CERAP must be conducted within five working days after a worker receives a new or transferred case for intact families. For placement cases, a CERAP must be conducted within five working days after a worker receives a new or transferred case when there are other children in the home. It is important that the new worker assess the family as quickly as possible and get his or her own assessment of the safety issues.

When a worker receives a case, either from investigative staff or from child welfare staff as a transfer and the new worker does not check "yes" on one of the safety factors checked "yes" on the last completed CERAP, an explanation must be made in Part B.1. explaining why the factor was not checked "yes". Has the safety factor been eliminated? If so, how?

No children in the home

Safety assessments are not conducted when there are no children residing in the home with the following exceptions:

- prior to returning a child home;
- when considering the commencement of unsupervised visits in home of parent or guardian.

In these instances, a safety assessment is to be conducted on the child's return home environment.

Clarifications Regarding Who Is Included in the Safety Assessment

At the initial safety assessment conducted during the child abuse and neglect investigation, all alleged child victims must be seen and, if verbal, interviewed out of the presence of the

caretaker and alleged perpetrator, if possible. All other children residing in the home must be seen prior to the conclusion of the formal investigation, and, if verbal, interviewed out of the presence of the caretaker and alleged perpetrator, if possible. Non-involved children who are present during the initial safety assessment are to be included in the assessment. If any children are not home at the time of an initial assessment, the assessment shall still be completed, with a new assessment completed when the children who were not present are seen.*

For all other safety assessments, all children residing in the home are to be included in the assessment and, if verbal, interviewed out of the presence of the caretaker and alleged perpetrator, if possible.*

All adult members of the household are included in the safety assessment to consider what effects they have on the children's safety.*

*When household members not present at an assessment, initial or otherwise, are eventually seen, a new assessment is only required when a change has taken place in the assessment. If no change has occurred, certify in Part B.2 that no change has occurred due to the assessment of the additional household members. Enter the date of certification on page 1 of the **CFS 1441**.

Child in Hospital

While a child victim who is in a hospital is safe in the hospital, the safety assessment is to be based on the child's return home environment. This explanation shall be made in Part B.1. Safety Factor Description of the **CFS 1441**.

Steps For Completing The Safety Assessment Protocol

The Safety Assessment Protocol must be completed in five sequential steps which correspond with the order of the **CFS 1441:**

Step 1 - Part A, Safety Factor Identification – page 3

The following list of factors are behaviors or conditions that may be associated with a child(ren) being in immediate danger of moderate to severe harm**. NOTE: At the initial safety assessment, all alleged child victims and all other children residing in the home are to be seen and if verbal, interviewed out of the presence of the caretaker and alleged perpetrator, if possible. If some children are not at home during the initial investigation, do not delay the safety assessment. Complete a new safety assessment on the children who are not home at the earliest opportunity only if the safety assessment changes. If there is no change, certify the current assessment at the bottom of page 4 and enter the date of the certification on page 1. For all other safety assessments, all children residing in the home are to be seen, and if verbal, interviewed out of the presence of the caretaker and alleged perpetrator, if possible.** When assessing children's safety, consider the effects that any adults or members of the

household who have access to them could have on their safety. Identify the presence of each factor by checking "Yes," which is defined as "clear evidence or other cause for concern."

When there are no safety factors that were checked "YES", the worker is to summarize the available information which indicates that no child is likely to be in immediate danger of moderate to severe harm.

Safety Factors and Examples

Child Endangerment Risk Assessment Protocol factors are listed below with examples to illustrate each factor.

The presence of any one of the listed behaviors and/or injuries does not in and of itself mean that a child should be determined to be unsafe. When considering the listed behaviors and/or injuries, a caseworker must also consider the following factors in making the determination of whether of child is safe or unsafe:

- The age and developmental status of the child;
- the mental, medical, and/or developmental status of the parent(s) or other person(s) responsible for the child's safety (i.e. Are they capable of and willing to protect the child's safety?);
- the type, severity, location, and/or extent of injury to a child; and
- the intent, severity and/or duration of the behaviors directed toward the child.

1. Any member of the household's behavior is violent and out of control.

· extreme physical or verbal anger or hostile outburst at child
· use of brutal or bizarre punishment (e.g., scalding with hot water, burning with cigarettes, forced feeding, confinement, over-strenuous exercise)
· use of guns, knives or other weapons in a violent way
· violently shakes or chokes baby or young child to stop a particular behavior
· behavior that seems to indicate a serious lack of self-control (e.g., reckless, unstable, raving, explosive)

2. Any member of the household describes or acts toward child in predominantly negative terms or has extremely unrealistic expectations.

· describes child as evil, stupid, ugly, a liar, a thief, or in some other demeaning or degrading manner
· curses and/or repeatedly puts child down
· uses a particular child in the family as a scapegoat
· expects a child to perform or act in a way that is impossible or improbable for the child's age (e.g., babies and toddlers expected not to cry, expected to be still for extended periods, be toilet trained or eat neatly)

3. There is reasonable cause to suspect that a member of the household caused moderate to severe harm or has made a plausible threat of moderate to severe harm to the child

- other than accidentally, adult caused moderate to severe injury (e.g., fractures, poisoning, suffocating, shooting, burns, bruises/welts, bite marks, choke marks)
- directly or indirectly threatens to cause moderate to severe harm in a believable manner (e.g., kill, starve, lock out of home, etc.)
- plans to retaliate against child for CPS investigation
- has used torture or physical force which bears no resemblance to reasonable discipline, or punished child beyond the duration of the child's endurance

4. There is reason to believe that the family is about to flee or refuse access to the child, and/or the child's whereabouts cannot be ascertained

- family has previously fled in response to a CPS or police investigation
- family has removed child from a hospital against medical advice
- family has history of keeping child at home, away from peers, school, other outsiders for extended periods
- family says they may flee or it appears as if they are preparing to flee

5. Caretaker has not, or is unable to provide sufficient supervision to protect child from potentially moderate to severe harm.

- caretaker does not attend to child to the extent that need for adequate care goes unnoticed or unmet (e.g., although caretaker present, child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge or be exposed to other serious hazards)
- caretaker leaves child alone (time periods varies with age and developmental stage)
- caretaker makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for child's care

6. Caretaker has not, or is unable to meet the child's medical care needs that may result in moderate to severe health problems if left untreated.

- caretaker does not seek treatment for child's immediate and dangerous medical condition(s)
- caretaker does not follow prescribed treatment for such condition(s)

7. Any member of the household has previously or may have previously abused or neglected a child, and the severity of the maltreatment, or the caretaker's or other adult's response to the prior incident, suggests that child safety may be an urgent and immediate concern.

- previous abuse or neglect that was serious enough to cause or could have caused severe injury or harm

- has retaliated or threatened retribution against child for past incidents
- escalating pattern of maltreatment
- does not acknowledge or take responsibility for prior inflicted harm to the child or explains incident(s) as deliberate
- non-reported anecdotal accounts of maltreatment
- child over dressed in warm weather (child may be required to wear long pants, long sleeved shirts to conceal bruises or other marks).

8. Child is fearful of people living in or frequenting the home.

- child cries, cowers, cringes, trembles or otherwise exhibits fear in the presence of certain individuals or verbalizes such fear
- child exhibits severe anxiety (e.g., nightmares, insomnia) related to situation associated with the person(s) in the home
- child reasonably expects retribution or retaliation from caretakers
- child is isolated from extended family members or others with whom the child feels safe.

9. Caretaker has not, or is unable to meet the child's immediate needs for food, clothing, and/or shelter; the child's physical living conditions are hazardous and may cause moderate to severe harm.

- no food provided or available to child, or child deprived of food or drink for prolonged periods
- child appears malnourished
- child without minimally warm clothing in cold months, no housing or emergency shelter; child must or is forced to sleep in streets, car, etc.; house is unsafe, without heat, etc.
- leaking gas from stove or heating unit; peeling lead base paint accessible to child; hot water/steam leaks from radiator
- dangerous substances or objects stored in unlocked lower shelves or cabinets or under sink or open garbage not disposed of properly throughout the household

10. Child sexual abuse is suspected and circumstances suggest that child safety may be an immediate concern.

- it appears that a member of household may have committed rape, sodomy or has had other sexual contact with child
- child may have been forced or encouraged to sexually gratify caretaker or others, or engage in sexual performances or activities
- access by possible or confirmed perpetrator to child continues to exist

11. Any member of the household's alleged or observed drug or alcohol use may seriously affect his/her ability to supervise, protect or care for the child.

- has misused a drug(s) or alcoholic beverage(s) to the extent that control of his or her actions is lost or significantly impaired; as a result, the household member is unable, or will likely be unable, to care for the child, or has harmed the child, or is likely to harm the child

12. Any member of the household's alleged or observed mental illness or developmental disability may seriously affect his/her ability to supervise, protect or care for the child.

- behavior that seems out of touch with reality, fanatical, bizarre, and/or extremely irrational
- lack of necessary supports has resulted in harm to the child or is likely to harm the child

13. The presence of domestic violence which affects caretaker's ability to care for and/or protect child from immediate, moderate to severe harm.

- alleged or observed domestic violence abuser is controlling and/or following the caretaker and child and has threatened to kill or seriously injure them
- alleged or observed domestic violence abuser has had recent violent outbursts that have resulted in injury or threat of injury to the child
- caretaker is unable to provide basic care and/or supervision for the child because of injury, incapacitation, forced isolation or other controlling behavior of the alleged or observed domestic violence abuser
- caretakers if forced under threat of serious harm to participate in or witness abuse of the child, and/or the child is forced under threat of harm to witness or participate in the abuse of the caretaker
- caretaker has unexplained injuries and denies that the alleged or observed abuser is responsible for abuse of the child or abuse of the caretaker, despite evidence to the contrary (from child(ren), neighbors, a LEADS check, previous police reports, etc.)

14. A paramour is the alleged or indicated perpetrator of physical abuse

- no biological or legal relationship exists between the paramour and the involved children
- paramour expresses negative attitudes or behaviors towards specific children in the household (e.g. unrealistic expectations for behavior, demeaning verbalizations, excessive corporal punishment, etc.)
- the paramour is misusing alcohol, prescription drugs, over the counter or illegal drugs
- paramour has a criminal background established through a LEADS and local law enforcement check

- paramour has been previously indicated as a perpetrator of child abuse or neglect
- paramour has a history with other states as an indicated perpetrator of child abuse or neglect
- paramour has a history of mental illness
- the paramour has a history of multiple unstable adult relationships
- the natural parent and/or children have expressed fear of the paramour
- the family has a current or previous protective service case
- the capacity of the natural parent to put the child's interest above his or her need for the relationship with the abusive paramour
- no steps were taken by the natural parent to protect his or her children from abuse or neglect by the current paramour
- the natural parent does not have the ability and willingness to continue protective behavior
- the ages of the children 10 through 6 years of age indicate that they are at high risk and the children who are younger than 6 years of age are at the greatest risk of abuse
- some of the children are hyperactive, behaviorally disordered, physically or mentally handicapped
- there are relational stresses between the paramour and parent
- there is no adult in the home who is willing and able to assist with ensuring the safety of the children

15. Other (possible examples)

- child's behavior likely to provoke caretaker to harm the child
- unexplained injuries
- abuse or neglect related to child death, or unexplained child death
- serious allegations with significant discrepancies or contradictions by caretaker, or between caretaker and collateral contacts
- caretaker refuses to cooperate or is evasive
- criminal behavior occurring in the presence of the child, or the child is forced to commit a crime(s) or engage in criminal behavior

Step 2 - Part B.1, Safety Factor Description – page 4 - When safety factors have been identified, record the safety factor by number from Section 1 A, page 3 and describe how the particular factor relates to specific individuals, behaviors, conditions and circumstances.

Part B.2, Persons Who Were Not Assessed and the Reasons Why – page 4

If any members of the household or others who are frequently part of the household have not been included in the assessment, list who they are, why they were not assessed, and a plan/timeframe for when the assessment of these persons will take place. (Examples, child away at camp, father or mother at work, grandmother who lives in the home away on errand, etc.). When they are assessed, if the assessment changes the results of the prior assessment, a new safety assessment (**CFS 1441**) is to be completed. If the assessment does not change, the worker shall record the fact here and certify by providing a date and

signature in the space provided. The supervisor shall also sign and date the certification. The date of the certification should be entered on page 1 of the **CFS 1441**.

Step 3 (Part B. 3, Family Strengths/Mitigating Circumstances – page 5) – For each safety factor checked "yes" in Section 1, describe any family strengths or mitigating circumstances which may serve to control or manage the safety factors. Sometimes the presence of a safety factor can be partially or fully controlled or eliminated by a family strength or mitigating circumstance. Therefore, consider all of the factors known about family strengths when making a decision regarding safety. Regular contact with a support person who can assure the safety of the child shall be considered a family strength.

Note: For the purpose of safety assessment, a protective effort must be made on the family's initiative and not as the result of the worker's suggestion in order for it to constitute mitigation. For example, in a case in which serious domestic violence creates the likelihood that a child would be moderately to severely harmed in the near future, but the mother has – on her own – moved to a shelter and obtained an order of protection, the child would be safe because the mother's protective capacity has mitigated the safety threat. In the same situation, if the worker initiates the mother's move to the shelter, it is the worker's and not the mother's capacity that has controlled the safety threat. In this case the child is considered unsafe and the move to the shelter is considered a safety plan.

If no safety factors are checked "yes" in Section 1, this section is not completed.

Step 4 - Section 2: Safety Decision

(Safe/Unsafe Decision) - Identify the safety decision as safe or unsafe based upon the assessment of all safety factors and any other information that is known about the case. When a decision is made that a child is "UNSAFE", a safety plan must be developed and implemented to avoid immediate danger to the child.

Signatures and Distribution of Form

The completed **CFS 1441, Safety Determination Form** must be signed and dated by the worker (DCFS or contracted private agency staff) and supervisor after completion. The supervisor or **designee** shall sign the form within 24 hours after the worker has signed it, if a factor has been marked "unsafe". If no safety factor has been marked unsafe and the worker has completed the **CFS 1441** on a weekend or holiday and more than 24 hours will elapse before the supervisor or designee can sign the form, the supervisor or designee shall sign the form on the next working day.

In accordance with **Appendix C, Case Record Organization** of **Administrative Procedure #5, Case Record Organization and Uniform Recording Requirements,** the completed **CFS 1441** shall be filed in the intake section of the case record for **CFS 1441's** completed during the child protection investigation or child welfare intake. **CFS**

1441's completed by child welfare staff shall be filed in the Client Service Planning Section of the case record.

Step 5 - Safety Plan

Development/Implementation

When the category of "UNSAFE" is checked in Section 2 a **CFS 1441-A, Safety Plan,** must be developed and implemented **or** one or more children must be removed from the home because without the plan they are likely to be in immediate danger of moderate to severe harm. The **CFS 1441-A** is a two page carbonized form intended to be completed by the investigator or worker in the home with copies left with the primary caregiver and the person most responsible for carrying out the safety plan, if different than the child's primary caregiver.

A safety plan is implemented when it is likely that a child could be moderately or severely harmed now or in the very near future. It should address whether a child should be removed from the home or if there are protective efforts that would permit the child to remain at home if a safety plan is developed and implemented. After the safety plan has been developed, it must be implemented to ensure that all of the designated tasks are completed effectively. The plan is to contain a time frame for implementation and continued monitoring and a contingency plan if the primary safety plan is no longer useful.

The worker who is responsible for implementing the plan must inform the family that their cooperation with the plan is voluntary and -- to the extent safely possible –must enlist the family's participation in the development of the plan. When the plan is developed the worker must explain it to the family and must provide the family with information about the potential consequences if the plan is refused or violated. If the family refuses to accept the plan or if the plan is violated, the worker must reassess the situation, consider protective custody and/or referral to the State's Attorney's Office for a court order. The worker shall document the family's agreement and commitment in the appropriate case record as described below under Signatures and Distribution of Safety Plan. The worker shall develop a backup plan which will be documented whenever necessary, particularly when family members have an active role in carrying out the primary goal.

Safety plans are temporary, usually short term, measures designed to control serious and immediate threats to children's safety. They must be adequate to assure the child's safety but as minimally disruptive to the child and family as is reasonably possible. It is important that safety plans be crafted to control specific threats and that there is a mechanism for ending each safety plan. Under no circumstance is a safety plan to serve as the solution to a long-term problem. Every safety plan must contain either specific time duration or a specific event upon which the plan will terminate. If the safety plan will terminate upon a specific event, the safety pan must explain in writing the steps necessary for the event to occur. In addition, the safety plan must explain the

consequences if the caretaker does not agree to implement the safety plan or fails to carry out the terms of the plan. Failure to agree to the plan or to carry out the plan may result in a reassessment of the home and possible protective custody and/or referral to the State's Attorney's Office for a court order to remove the children from the home. Caretakers will then have the opportunity to plead their cases in court.

A new safety assessment must be completed every five working days following the determination that any child in a family is **unsafe** and a safety plan is implemented. If the new safety assessment determination is that the child or children remain unsafe and the safety plan will continue, the worker must make a notation in Part B1 of the **CFS 1441** documenting the reason or reasons why the safety plan should remain in effect. Such assessment must continue until either all children are assessed as being safe **or** all unsafe children are removed from the **legal** custody of their parents/caretakers. This assessment should be conducted considering the child's safety status as if there was no safety plan (i.e., Would the child be safe WITHOUT the safety plan?). This safety assessment will determine the point at which a safety plan may be terminated or its conditions modified. When a safety plan has been modified, the worker must obtain the parent/caretaker(s)' and other adult participant's signatures on a new **CFS 1441-A** and must provide the parent/caretaker(s) and other adult participants with a copy of the new **CFS 1441-A** documenting the conditions of the modified safety plan.

Such safety assessments -- conducted to reconsider the continued need for safety plans -- are the responsibility of the assigned Child Protection Service Worker whenever there is a pending investigation. When the investigation is complete and an Intact Family case is opened, the assigned Child Welfare Specialist assumes this responsibility.

The safety plan is to be used to **control** or immediately resolve or reduce the potential imminent risk of moderate to severe harm to a child until a more stable/permanent change can take place. This step requires a written description of what will be done or what actions will be taken to protect the child(ren), who will be responsible for implementing the components of the safety plan and how/who will monitor the safety plan.

The worker (DCFS or Purchase of Service) who initiates a safety plan is continuously responsible for implementation and monitoring of the safety plan. If services to a child(ren) and family are to be transferred to another worker (DCFS or POS) after the safety plan has been initiated, the worker who initiated the safety plan will remain responsible for the safety plan until the responsibility for services to the child(ren) and family are transferred to another worker. The worker transferring the case shall discuss the case and the terms of the safety plan with the new worker at the time of the case handoff. This responsibility is applicable regardless of whether the worker is DCFS or POS staff.

NOTE: Safety Plans are not used when the case is assessed to be safe. If the case is considered safe but the worker has concerns about potential risk factors that need to be addressed by the parent, the worker may use the service plan to address those concerns. Similar to the service plan used for reunification cases, examples of how the service plan

may be utilized include a description written by the parents with the help of the caseworker of how the parents plan to meet the child's needs for safety, identification of those persons the parent can call upon for support, identification of persons, such as other family members, the child can call upon (if old enough) if the child needs help. Other alternatives include protective day care and unannounced monitoring visits.

If a safety plan cannot prevent placement and the child must be removed from the home, note that fact on the first page of the **CFS 1441-A, Safety Plan**. The signature page of the **CFS 1441-A** is not completed in these instances when protective custody must be taken. Follow the instructions contained in **Rule 300.120 and Procedures 300.80, Taking Children into Protective Custody**.

Signatures and Distribution of Safety Plan

A completed Safety Plan must be signed and dated by the worker (DCFS or contracted private agency staff) and the child's primary caregiver and the person most responsible for implementing the safety plan, if different than the primary caregiver, and any other persons responsible for components of the safety plan.

A copy of the completed form shall be given to the parent/guardian/primary caregiver, and a copy to the person most responsible for implementing the safety plan, if other than the primary caregiver. The original shall be filed in the child/family case file of the child protection investigator or the child welfare worker and forwarded to the appropriate service worker when a case is transferred.

The respective supervisor or designee shall sign the completed Safety Plan within 24 hours after the worker has signed it. If the worker has signed the **CFS 1441-A** on a weekend or holiday and more than 24 hours will elapse before the supervisor can sign the form, the worker shall obtain the verbal approval of the supervisor or designee by phone. The supervisor shall then sign the Safety Plan on the next working day. If the supervisor will not be available to sign the form on the next working day, but has access to a FAX machine, the Safety Plan shall be faxed for the supervisor's signature. In all other instances when the supervisor who gave verbal approval will not be available to sign the Safety Plan due to a prolonged absence, another supervisor may sign the plan.

When a safety plan is terminated because all children included in the plan are assessed to be safe, the worker must provide a copy of the **CFS 1441B** to all parent/caretaker(s) and other adult participants who signed the **CFS 1441A** or who were actively involved in the safety plan.

Safety Plan Team Assessment (SPTA)

The SPTA provides a venue to allow the family to express any objections and/or concerns they may have about their safety plan at a meeting with the investigative specialist, his or her supervisor and a Child Protection Manager. Persons subject to a

safety plan may request a Safety Plan Team Assessment when any of the following conditions exist:

- The safety plan has been in effect for 14 calendar days; and
- The involved parent or caretaker ha been advised that there is a possibility the children will be taken into protective custody if a safety plan cannot be implemented; and
- A condition of the plan prohibits or restricts physical and/or verbal contact with parent and his or her biological or adopted child; or
- A condition of the plan prohibits or restricts a person's spouse, child, parent or legal guardian from residing in the home; or
- If the alleged perpetrator is a child, and a condition of the safety plan prohibits contact between the alleged child perpetrator and his or her parents, legal guardians or other adult relative who live with the alleged child perpetrator in his or her home.

Persons are excluded from requesting a SPTA if they are subject to a court order that imposes conditions regarding contact with children who are the subjects of a child abuse and neglect investigation. These court orders include orders entered in a criminal proceeding under the Illinois Criminal Code or civil proceedings under the Illinois Juvenile Court Act, the Illinois Marriage and Dissolution of Marriage Act or any civil proceeding that sets forth conditions regarding contact with children.

The Child Protection Manager facilitating an SPTA meeting will prepare documentation (**Safety Plan Team Assessment Meeting Form**, **CFS 1441C**) at the conclusion of the meeting that details issues discussed and agreements that were reached. Each person in attendance at the SPTA receives a copy of the **CFS 1441C** as well as a copy of the current or revised safety plan. There are three possible outcomes from an SPTA:

- DCFS and the family agree to maintain the current safety plan; or
- DCFS and the family agree to modify the current safety plan; or
- The family informs DCFS that they will not agree to any safety plan.

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